Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JEFFREY B WOOD MD
15400 SOUTHWEST FREEWAY SUITE 100
SUGAR LAND TX 77478

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-07-0028-01

MFDR Date Received
AUGUST 28, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Code E0748NU…has been denied as not authorized. We obtained the authorization on 12.06.05. 63047-59 This procedure code was also denied as 'the procedure is incidental to the primary procedure and does not warrant separate reimbursement.' This procedure was denied in error and should be reconsidered. According to Medicare Trailblazer, this procedure code is not globaled to any other procedure code and is to be paid separately. 22830 According to the Medicare Trailblazer, this code is not bundled to any other procedure code and is to be paid separately."

Amount in Dispute: $11,178.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a position summary in the response packet.

Response Submitted by: Coventry Health Care

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 15, 2005	HCPCS Code E0748NU Osteogenesis stimulator, electrical, noninvasive, spinal applications -	$7,392.00	$0.00
	CPT Code 63047-59 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar	$2,162.00	$187.88
	CPT Code 22830 Exploration of Spinal Fusion	$1,624.00	$0.00
TOTAL		$11,178.00	$187.88

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Former 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed services.
3. Former 28 Texas Administrative Code §134.600, effective March 14, 2004, 29 TexReg 2349, requires preauthorization for specific healthcare treatment and services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 97- Payment is included in the allowance for another service/procedure.
   - X815-This procedure is incidental to the primary procedure, and does not warrant separate reimbursement .
   - 62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
   - B298-Authorization should have been obtained prior to service.
   - W1-Workers compensation state fee schedule adjustment.
   - Z560-This charge for this procedure exceeds the fee schedule or usual and customary allowance.
   - U849-This multiple procedure has reduced 50% according to fee schedule or usual and customary guidelines.

Issues

1. Does a preauthorization issue exist?
2. Is the requestor entitled to additional reimbursement for code 63047-59?
3. Is the value of code 22830 included in the value of another service/procedure?

Findings

1. Per 28 Texas Administrative Code §134.600(h) "The non-emergency health care requiring preauthorization includes: (5) all external and implantable bone growth stimulators."

   The requestor indicated that the disputed HCPCS code E0748-NU was for a bone growth stimulator.

   The respondent denied reimbursement for HCPCS code E0748-NU based upon reason codes "62 and B298."

   The requestor states that "We obtained the authorization on 12.06.05." The requestor did not submit a copy of the December 6, 2005 preauthorization report to support position. As a result, reimbursement is not recommended.

2. According to the explanation of benefits, the respondent initially denied reimbursement for CPT code 63047-59 based upon reason codes "97 and X815." Upon reconsideration, the respondent did not maintain the denial and issued payment of $507.99 on June 5, 2006. The issue in dispute is whether additional payment is due.

   28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77478, which is located in Harris County.

   The Medicare allowable for code 63047 is $1,113.40.

   The MAR for CPT code 63047 in Harris County is $1,391.75. This code is subject to multiple procedure discounting; therefore, $1,391.75 X 50% = $695.87. The respondent paid $507.99. As a result, the requestor is due $187.88.

3. According to the explanation of benefits, the respondent denied reimbursement for CPT code 22830 based upon reason codes "97 and X815."

   A review of the submitted medical bill finds that on the disputed date of service the requestor billed for the following services: E0748NU, 22612, 22849-51, 63042-50, 63047-59, 22830, 22852, 63044-LT, 20936, and 20931.

   Per CCI edits, CPT code 22830 is a component of code 22612. A modifier may be appended to code 22830 to differentiate the service. A review of the submitted medical bill finds that the requestor did not append a

modifier to code 22830. As a result, code 22830 is a component of 22612, and reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $187.88.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $187.88 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

		10/30/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.